Claims Clues

A Publication of the AHCCCS Claims Department April, 1998

New Recipient ID Card Being Developed

AHCCCS is developing a plastic identification card for recipients which will replace the six different paper ID cards currently in use.

A magnetically encoded strip on the card will enable providers to "swipe" the card through a card reader and obtain current eligibility and enrollment information. The transaction would be similar to the manner in which customers use credit and debit cards at point-of-sale terminals in stores.

Information will de displayed in a small window of the card reader. The provider also will have the option of printing a hard copy of the information.

Because the card will access recipient files in the AHCCCS system, the most current eligibility and enrollment information always will be available to providers.

Recipients will be advised that the ID card is a permanent card which they must carry at all times.

More information about the new recipient ID card, including information on vendors who can supply providers with the card reading device, will appear in future issues of *Claims Clues*. ❒

AHCCCS to Require Tax ID on Claim Form

AHCCCS has begun to capture providers' federal tax identification numbers, and providers soon will be required to enter their tax ID numbers on claim forms.

AHCCCS began capturing tax IDs on February 1. Effective May 1, all claims must include the providers tax ID number. Claims without a tax ID will be denied.

On a UB-92 claim form, the provider's tax ID is entered in Field 5 near the top of the form.

On the HCFA 1500 claim form, the tax ID is entered in Field 25 near the lower left corner.

On the Universal form used for pharmacy claims, the tax ID should be entered in the signature box in the middle of the form. ❒

New Claim Edits Reflect CCI Policy

Fee-for-service providers may begin seeing new edits reflecting Medicare's Correct Coding Initiative (CCI).

Claims for the same provider, recipient, and same date of service are subject to CCI edits and audits.

The CCI edit numbers, edit messages, and the results are:

- L140.1 - Invalid Coding Combination; Mutually Exclusive Code Paid (Deny)
- L140.2 - Invalid Coding Combination; Component Previously Paid (Deny)
- L140.3 - Invalid Coding Combination; Comprehensive Previously Paid (Deny)
- L140.4 - Invalid Coding Combination; Multiple Component Codes (Approve. Post pay review and possible recoupment)
- L140.5 - Invalid Coding Combination; Ventilator Mgmt With E/M Code (Deny)
- L140.6 - Invalid Coding Combination; Discharge Mgmt With E/M Code (Deny)

The purpose of CCI is to encourage consistent and correct coding and ensure appropriate reimbursement.

Correct coding means billing a group of procedures with the appropriate comprehensive code. "Unbundling" is the billing of multiple procedure codes for a group of services that are covered by a single comprehensive code.

Examples of *incorrect* coding:

- Fragmenting a service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Downcoding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

(Continued on Page 2)

Billing of Outpatient Services Clarified

Charges for hospital outpatient services that result in a *direct* admission to the hospital must be included on the inpatient UB-92 claim submitted to the AHCCCS Administration.

If a recipient is treated in the emergency room, observation room, or other outpatient department and then admitted directly to the hospital, the outpatient charges must be billed on the inpatient claim. However, if the recipient is discharged from the emergency room, observation room, or other outpatient department and then subsequently admitted, the hospital would submit separate claims to AHCCCS.

The claim for the outpatient services would be priced at the outpatient cost-to-charge ratio, while the inpatient claim would be reimbursed at the appropriate tier(s).

To enable AHCCCS to distinguish inpatient and outpatient UB-92 claims for the same recipient for the same date of service, hospitals must include the admit hour and the discharge hour on both the outpatient and inpatient claim.

For example, assume that a recipient is treated in the emergency room for injuries suffered in an automobile accident. If the recipient goes from the emergency room to a hospital bed, the emergency room charges must be included on the inpatient claim. The charges may not be billed separately to AHCCCS as an outpatient claim.

However, if the recipient is discharged from the emergency room, goes home, and then returns to the hospital and is admitted that same day, the emergency room services should be billed to AHCCCS as an outpatient claim.❒

Billing for SNF Bed Hold Days Requires Appropriate Bill Type and Patient Status

When billing for bed hold days, nursing facilities must split bill and submit claims on separate UB-92 claim forms using the appropriate bill types and patient status codes.

Nursing facilities must bill for bed hold and therapeutic leave days using revenue codes 183 (Leave of absence - therapeutic) or 185 (Leave of absence - bed hold).

The following example illustrates proper billing for bed hold days:

A recipient residing in a skilled nursing facility is hospitalized on April 11. The recipient is discharged from the hospital on April 14 and returns to the nursing facility that day. The recipient remains in the nursing facility through April 30.

When billing for the month of April, the nursing facility would submit the following three claims to AHCCCS:

First Claim

Dates	04/01 - 04/11
Revenue code	073
Bill Type	212
Patient status	02

Second Claim

Dates	04/11 - 04/14
Revenue code	185
Bill Type	213
Patient status	02

Third Claim

Dates	04/14 - 04/30
Revenue code	073
Bill Type	214
Patient status	30

Revenue code 185 is authorized when short-term hospitalization is medically necessary. Revenue code 183 is authorized for a home visit by the recipient. ❒

New Claim Edits Reflect CCI Policy

(Continued from Page 1)

CCI edits are performed on a post-payment basis. Only paid claims are selected for this process.

If the CCI process identifies that a service has been unbundled, payment for that line will be recouped. The line will be denied, and the remittance advice will indicate one of the edit codes listed on Page 1.

The recouped amount will appear as a credit (negative) balance. ❒

Hospital Therapy Claims Must Use '98 CPT Codes

Hospitals that provide outpatient therapy services must ensure that UB-92 claims submitted to AHCCCS reflect 1998 changes in CPT and HCPCS codes that must be included on the claim form.

All outpatient physical therapy for acute care fee-for-service recipients requires prior authorization from the AHCCCS Prior Authorization Unit. Hospitals must supply the PA Unit with the appropriate revenue code and CPT/HCPCS code for the covered therapy when obtaining PA. (See table on Page 3).

Units must be consistent with CPT/HCPCS code definitions.

For example, assume that a hospital bills revenue code 421 (PT/Visit) with CPT code 97116 (Therapeutic procedure, one or more areas, each 15 minutes; gait training). Each 15-minute increment represents one unit.

If services were provided for 30 minutes, the hospital would bill two units. If services were provided for 45 minutes, the hospital would bill three units, and so on.

Outpatient physical therapy rendered as part of emergency treatment does not require prior authorization. ❒

UB-92 Hospital Billing Requirements for Rehabilitative Services
(New Codes for 1998 Shown in Bold Italics)

Physical Therapy (PT)	Acute Care Recipients • Covered in outpatient setting • PA *required* unless Medicare is primary Acute Care Recipients Under 21 • Covered in outpatient setting • PA *not* required
Revenue Code	**HCPCS/CPT Codes**
420 Physical Therapy	Not Allowed
421 PT/Visit	97010 - 97139, 97250 - 97546, 97770 - 97799
422 PT/Hourly	Not Allowed
423 PT/Group	97150
424 PT/ Evaluation	***97001, 97002,*** 97703, 97750, , Q0086 **(Q0103 and Q0104 deleted)**
429 Other PT	97010-97799
Occupational Therapy (OT)	Acute Care Recipients • Not covered in outpatient setting • Covered if recipient in nursing facility • PA required for recipient in nursing facility unless Medicare is primary Acute Care Recipients Under 21 • Covered in a outpatient setting • PA not required
Revenue Code	**HCPCS/CPT Codes**
430 OT	Not Allowed
431 OT/ Visit	97500-97546, 97770-97799 **(H5300 deleted)**
432 OT/Hour	Not Allowed
434 OT/Evaluation	***97003, 97004***, 97703, 97750 **(Q0109 and Q0110 deleted)**
439 Other OT	97500-97546, 97770-97799 **(H5300 deleted)**
Speech Therapy (ST)	Acute Care Recipients • Not covered in outpatient setting • Covered if recipient in nursing facility • PA *required* for recipient in nursing facility unless Medicare is primary Acute Care Recipients Under 21 • Covered in outpatient setting • PA *not* required
Revenue Code	**HCPCS/CPT Codes**
440 Speech Pathology	Not Allowed
441 Speech/Visit	92507
442 Speech/Hour	Not Allowed
443 Speech/Group	92508
444 Speech/Evaluation	92506, ***92525***
449 Other Speech	92506, 92507, ***92526***

Pharmacy May Not Bill for Home IV, Infusion

Pharmacies may not provide home IV antibiotic and infusion therapy services to AHCCCS recipients.

While pharmacies may bill AHCCCS for the supplies used in such services, the administration of home IV and infusion services must be performed by an AHCCCS-registered, licensed, and Medicare-certified home health agency.

Both the pharmacy and the home health agency must obtain prior authorization from the AHCCCS Administration Prior Authorization Unit. Pharmacy providers will not be authorized to administer the IV antibiotic and infusion therapy.

The home health agency should use procedure code Z3470 to bill for home IV antibiotic therapy services. Procedure code Z3495 should be used to bill for home infusion therapy services. ❒

HCFA 1500 Billing Update

Labs, Radiology Facilities Must Use Valid Diagnosis Codes

Laboratories and radiology facilities must enter a valid diagnosis code on the HCFA 1500 claim form when submitting claims to the AHCCCS Administration.

AHCCCS will not accept the ICD-9 diagnosis code 799.9 (Other unknown and unspecified cause) on claims from laboratories and radiology facilities.

AHCCCS requires that at least one valid diagnosis code be entered in Field 21 of the HCFA 1500 claim form. The reference to the diagnosis must be entered in Field 24E. ❒

"G" Codes Not Accepted for Routine Screenings

Providers should not bill the AHCCCS Administration for routine screenings using the "G" codes from the HCPCS Manual.

AHCCCS allows routine screenings, and providers should use the appropriate CPT codes when billing for these services.❒

Boston-based Firm Selected as New TPL Contractor

Public Consulting Group (PCG), a Boston-based management consulting firm, has been contracted by the AHCCCS Administration to perform third party liability (TPL) recovery operations.

PCG replaces Health Management Systems Inc. (HMS) as the TPL contractor.

PCG is responsible for identifying and recovering funds for five programs -- estate recovery, casualty and tort recovery, special treatment trust recovery, health insurance recovery, and adoption recovery.

Providers, other than hospitals, must notify PCG within 30 days after rendering medical services for a condition or injury resulting from circumstances reflecting a probable first- or third-party liability source to assist with the filing of liens.

Hospitals must notify PCG within 30 days after discharge and may meet the notification requirement by providing a copy of their lien.

Notification forms are available from PCG. Completed forms should be sent to:

Public Consulting Group, Inc.
Attn: Recovery Unit
P.O. Box 2238
Boston, MA 02107-2238

The forms also may be faxed to PCG at (617) 426-5389.

The PCG Recovery Unit may be contacted by calling, toll free, 1-888-378-2836. ❒

Fee-For-Service Capped Fee Schedule Updated

The AHCCCS Administration has updated the fee-for-service capped fee schedule effective for dates of service on and after April 1, 1998.

Based on current utilization and mix of services, the aggregate impact on fee-for-service payments as a result of these rate changes is estimated to be a decrease of approximately 2.1 per cent as compared to 1997 fees.

To obtain a fee schedule, providers should contact the Claims Customer Service Unit. ❒